KENTUCKY DEPARTMENT OF INSURANCE
MEDICAID PROMPT PAYMENT COMPLAINT FORM

Please complete this information and submit by mail or fax to:

Medicaid Prompt Payment Compliance Branch
Kentucky Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517

502-564-6106
502-564-2555 Fax
DOI.MCOCompliance@ky.gov
http://insurance.ky.gov

GENERAL PROVIDER INFORMATION

Provider Name: _____ **NPI #:** _____

Provider Specialty: _____

Provider's Place of Service Address: _____

City: _____ **St:** _____ **ZIP:** _____

Provider's Contact Person's Name: _____

Contact Person's Company: _____

Mailing Address: _____

City: _____ **St:** _____ **ZIP:** _____

Phone: _____ **Fax:** _____ **E-mail:** _____

On behalf of the provider, I certify that the information is correct:

Name: _____ **Title:** _____ **Date:** _____

Managed Care Organization (MCO) Name: _____

Were you a participating provider with this MCO on the dates of service? ☐Yes ☐ No

Medicaid Member's Name: _____ **Medicaid Member ID #:** _____

DESCRIPTION OF CLAIM AND VERIFICATION OF UNTIMELY PAYMENT

Please complete and submit with General Provider Information and copy this form if needed for additional dates of services.
Please attach copies of all documentation necessary to explain and support your complaint.

Claim#: _____ **Disputed Service Line(s):** _____

Date services rendered: _____ **Date claim first sent to MCO:** _____

Sent by: ☐ **Mail** ☐ **Electronic** **Attach copy of original billing instrument (CMS 1500—UB-04) and EOBs**

Reason(s) for complaint:
(Limit 1000 characters) _____

Has the Managed Care Organization (MCO):

Acknowledged receipt of the claim? ☐**Yes** ☐**No** **If yes, when?** _____

Denied receipt of the claim? ☐ **Yes** ☐ **No**

Made any payment? ☐ **Yes** ☐ **No If yes, how much and when?** _____

Recouped any amount on this claim?☐**Yes**☐**No If yes, how much & when?** _____

Denied the claim in writing?☐**Yes** ☐**No** **If yes, how much & when?** _____

Have you filed an appeal/grievance or dispute/re-consideration with the MCO on this claim? ☐ **Yes** ☐ **No**

If yes, when? _____ **Has there been a determination?** ☐ **Yes** ☐ **No (Attach copy)**

Has a state fair (administrative) hearing been filed on this claim? ☐ **Yes** ☐ **No**

Provider Name: _____ Member Name: _____ Page _____ of _____

Use this section to add additional claims with different dates of services regarding the same Medicaid Member. Please attach copies of all documentation necessary to explain and support your complaint.

Claim#: _____ **Disputed Service Line(s):** _____

Date services rendered: _____ **Date claim first sent to MCO:** _____

Sent by: ☐ **Mail** ☐ **Electronic Attach copy of original billing instrument (CMS 1500—UB-04) and EOBs**

Reason(s) for complaint:
(Limit 1000 characters)

Has the Managed Care Organization (MCO):

Acknowledged receipt of the claim? ☐**Yes** ☐**No If yes, when?** _____

Denied receipt of the claim? ☐ **Yes** ☐ **No**

Made any payment? ☐ **Yes** ☐ **No If yes, how much and when?** _____

Recouped any amount on this claim?☐**Yes**☐**No If yes, how much & when?** _____

Denied the claim in writing?☐**Yes** ☐**No If yes, how much & when?** _____

Have you filed an appeal/grievance or dispute/re-consideration with the MCO on this claim? ☐ **Yes** ☐ **No**

If yes, when? _____ **Has there been a determination?** ☐ **Yes** ☐ **No (Attach copy)**

Has a state fair (administrative) hearing been filed on this claim? ☐ **Yes** ☐ **No**

Provider Name: _____ Member Name: _____ Page ____ of ____

Use this section to add additional claims with different dates of services regarding the same Medicaid Member. Please attach copies of all documentation necessary to explain and support your complaint.

Claim#: _____ **Disputed Service Line(s):** _____

Date services rendered: _____ **Date claim first sent to MCO:** _____

Sent by: ☐ **Mail** ☐ **Electronic Attach copy of original billing instrument (CMS 1500—UB-04) and EOBs**

Reason(s) for complaint:
(Limit 1000 characters)

Has the Managed Care Organization (MCO):

Acknowledged receipt of the claim? ☐**Yes** ☐**No If yes, when?** _____

Denied receipt of the claim? ☐ **Yes** ☐ **No**

Made any payment? ☐ **Yes** ☐ **No If yes, how much and when?** _____

Recouped any amount on this claim?☐**Yes**☐**No If yes, how much & when?** _____

Denied the claim in writing?☐**Yes** ☐**No If yes, how much & when?** _____

Have you filed an appeal/grievance or dispute/re-consideration with the MCO on this claim? ☐ **Yes** ☐ **No**

If yes, when? _____ **Has there been a determination?** ☐ **Yes** ☐ **No (Attach copy)**

Has a state fair (administrative) hearing been filed on this claim? ☐ **Yes** ☐ **No**

Provider Name: _____ Member Name: _____ Page ____ of ____

Use this section to add additional claims with different dates of services regarding the same Medicaid Member. Please attach copies of all documentation necessary to explain and support your complaint.

Claim#: _____ **Disputed Service Line(s):** _____

Date services rendered: _____ **Date claim first sent to MCO:** _____

Sent by: ☐ **Mail** ☐ **Electronic Attach copy of original billing instrument (CMS 1500—UB-04) and EOBs**

Reason(s) for complaint:
(Limit 1000 characters)

Has the Managed Care Organization (MCO):

Acknowledged receipt of the claim? ☐**Yes** ☐**No If yes, when?** _____

Denied receipt of the claim? ☐ **Yes** ☐ **No**

Made any payment? ☐ **Yes** ☐ **No If yes, how much and when?** _____

Recouped any amount on this claim?☐**Yes**☐**No If yes, how much & when?** _____

Denied the claim in writing?☐**Yes** ☐**No If yes, how much & when?** _____

Have you filed an appeal/grievance or dispute/re-consideration with the MCO on this claim? ☐ **Yes** ☐ **No**

If yes, when? _____ **Has there been a determination?** ☐ **Yes** ☐ **No (Attach copy)**

Has a state fair (administrative) hearing been filed on this claim? ☐ **Yes** ☐ **No**

Provider Name: _____ Member Name: _____ Page ____ of ____

Use this section to add additional claims with different dates of services regarding the same Medicaid Member. Please attach copies of all documentation necessary to explain and support your complaint.

Claim#: _____ **Disputed Service Line(s):** _____

Date services rendered: _____ **Date claim first sent to MCO:** _____

Sent by: ☐ **Mail** ☐ **Electronic Attach copy of original billing instrument (CMS 1500—UB-04) and EOBs**

Reason(s) for complaint:
(Limit 1000 characters)

Has the Managed Care Organization (MCO):

Acknowledged receipt of the claim? ☐**Yes** ☐**No If yes, when?** _____

Denied receipt of the claim? ☐ **Yes** ☐ **No**

Made any payment? ☐ **Yes** ☐ **No If yes, how much and when?** _____

Recouped any amount on this claim?☐**Yes**☐**No If yes, how much & when?** _____

Denied the claim in writing?☐**Yes** ☐**No If yes, how much & when?** _____

Have you filed an appeal/grievance or dispute/re-consideration with the MCO on this claim? ☐ **Yes** ☐ **No**

If yes, when? _____ **Has there been a determination?** ☐ **Yes** ☐ **No (Attach copy)**

Has a state fair (administrative) hearing been filed on this claim? ☐ **Yes** ☐ **No**

Provider Name: _____ Member Name: _____ Page ____ of ____

Use this section to add additional claims with different dates of services regarding the same Medicaid Member. Please attach copies of all documentation necessary to explain and support your complaint.

Claim#: _____ **Disputed Service Line(s):** _____

Date services rendered: _____ **Date claim first sent to MCO:** _____

Sent by: ☐ **Mail** ☐ **Electronic Attach copy of original billing instrument (CMS 1500—UB-04) and EOBs**

Reason(s) for complaint:
(Limit 1000 characters)

Has the Managed Care Organization (MCO):

Acknowledged receipt of the claim? ☐**Yes** ☐**No If yes, when?** _____

Denied receipt of the claim? ☐ **Yes** ☐ **No**

Made any payment? ☐ **Yes** ☐ **No If yes, how much and when?** _____

Recouped any amount on this claim?☐**Yes**☐**No If yes, how much & when?** _____

Denied the claim in writing?☐**Yes** ☐**No If yes, how much & when?** _____

Have you filed an appeal/grievance or dispute/re-consideration with the MCO on this claim? ☐ **Yes** ☐ **No**

If yes, when? _____ **Has there been a determination?** ☐ **Yes** ☐ **No (Attach copy)**

Has a state fair (administrative) hearing been filed on this claim? ☐ **Yes** ☐ **No**